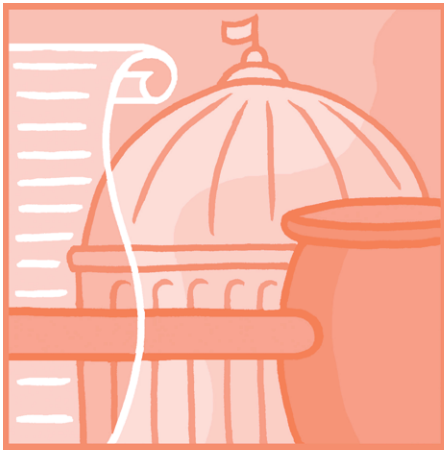

The Politics of Health Reform

Health Reform Redux: Learning From Experience and Politics

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The 2008 presidential campaign season featured health care reform proposals. I discuss 3 approaches to health care reform and the tools for bringing about reform, such as insurance market reforms, tax credits, subsidies, individual and employer mandates, and public program expansions. I also discuss the politics of past and current health care reform efforts.

Market-based reforms and mandates have been less successful than public program expansions at expanding coverage and controlling costs. New divisions among special interest groups increase the likelihood that reform efforts will succeed.

Federal support for state efforts may be necessary to achieve national health care reform. History suggests that state-level success precedes national reform. History also suggests that an organized social movement for reform is necessary to overcome opposition from special interest groups. (*Am J Public Health.* 2009;99:779–786. doi:10.2105/AJPH.2008.148510)

BEGINNING WITH PRESIDENT Theodore Roosevelt in 1912, political efforts to control health care costs and provide health care for all have resurfaced every 10 to 20 years in the United States, yet we have failed to achieve the universal national health care program so often recommended.[1] According to the US Census Bureau, 45.7 million Americans were uninsured in 2007.[2] The United States spends nearly twice as much per capita as its economic rivals for a health care system with inferior outcomes.[3–6] Americans pay the price of inaction: soaring health care costs with deteriorating access to and quality of care. These costs have long been evident, yet no definitive action has been taken.[7]

RECOMMENDATIONS FOR REFORM

The Citizens' Health Care Working Group was created by bipartisan federal legislation in 2003 and charged "to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage" and "to provide for a vote by Congress on the recommendations that result from the debate."[8] It issued its report to the president and the nation in September 2006.[9] The Institute of Medicine,[10] the American College of Physicians,[11] and the Commonwealth Fund[12] have also recently published recommendations for reform policy.

All 4 reports agree that America needs a health care system that provides universal continuous insurance coverage that is affordable and sustainable for individuals, families, and society and care that is effective, efficient, safe, timely, patient centered, and equitable. These reports also identified 3 possible structures of a reformed system: a combination of tax incentives and subsidies with an improved private individual insurance market; a single public social insurance, such as an improved and expanded Medicare for all; or a hybrid involving a mixed private–public group insurance system with responsibility for financing shared between individuals, business, and the government.

All 4 reports also agree that mandates, achieved by a new law or universal enrollment in a single public plan, are necessary. Other approaches are unlikely to enable the creation of a high-performance system or to adhere to the principles delineated by the Institute of Medicine[10] and supported by most Americans, according to the Citizens' Health Care Working Group.[9] All the reports agree that tax incentives and private insurance market reforms alone will not yield universal coverage without a requirement that all individuals purchase insurance.

All 4 reports also agree that without an integrated and organized health care system, the data needed for evaluation and the incentives needed to achieve greater efficiency and effectiveness are unlikely to be available. They all agree that the government must act to guarantee coverage for all and to help create a system that will control costs and improve outcomes.

THE 2008 CAMPAIGN PROPOSALS

Americans agree that a national health program is needed. According to a Pew Research Center for the People and the Press report in 2005, Americans, including a majority of conservatives, favor government health insurance for all, even if taxes increase.[13]

In the 2008 US presidential race, health care reform was a key domestic issue. Kaiser Family Foundation polls have indicated that fewer than 17% of likely voters wanted the presidential candidate of their choice to maintain the health care status quo. According to these polls, 70% of

likely voters said they wanted a complete overhaul or major change to the system. Their priorities were cost control, expanded coverage, and improved quality.[14]

Both Republican and Democratic candidates put forth a range of proposals to address these issues.[15] Republicans proposed mainly free market solutions, such as tax incentives to purchase health insurance (deductions and credits toward the purchase of health insurance), and improved private insurance markets, without mandates for universal coverage. Democrats proposed a mixture of public and private coverage with government guarantees, public program expansions, and subsidies for the working poor and employers to purchase a choice of public or private insurance. Their plans would include mandates with the potential to create universal coverage.

Both parties supported improved insurance markets, although they differed on the level of regulatory oversight. Both also supported electronic health records, malpractice reform, improved chronic disease management programs, and increased preventive and public health efforts. (A more detailed comparison is available at http://health08.org/analysis.cfm.)

THREE APPROACHES TO REFORM

Market Forces and Market-Based Reforms

When the Clinton health care plan collapsed in 1994, the insurance industry adopted its approach to reform of the health care system—specifically, competition among managed care organizations under market forces.[16–18]

In the late 1990s, record numbers of not-for-profit hospitals and health insurers either merged or were purchased.[19] Many were converted to for-profit entities, so that formerly public assets were transferred to stockholders and health care executives. Megamergers became the rule, and several chief executive officers received multimillion- and even billion-dollar personal payouts.[20,21] Control of doctors and hospitals migrated from local communities to national corporate offices. Unlike caregivers, such as doctors and nurses, whose personal financial interests are tempered by a legal and moral duty to first serve the interests of their patients, the corporate officers of these new for-profit corporations had a fiduciary duty to protect their stockholders, not the insured patients whose lives now rest in their hands.

Doctors, already encumbered with paperwork, malpractice concerns, and managed care contractual issues, now had to navigate the Scylla and Charybdis of a patient's illness and the health insurance bureaucracy. Nurses, the first to feel the effects of downsizing in health care, found themselves scrambling to provide decent care to the sickest hospitalized patients.[22–25] At the same time, the workforce of clerks and insurance bureaucrats required for this market competition grew exponentially.[26,27]

Supposedly, competition in the face of market forces drives down costs, maintains quality, and makes insurance more affordable.[16–18] However, market forces have not significantly moderated health care costs and lack of insurance. Health insurance premium increases at double the inflation rate have remained the rule for most businesses that provide health insurance.[28] Out-of-pocket costs to working people have jumped substantially because of decreased coverage and increased copayments.[29–31] Fewer patients than ever have free choice of doctor or hospital.[32,33]

In 1990, 32 million persons were uninsured.[34] Despite incremental federal programs such as the Health Insurance Portability and Accountability Act, the Consolidated Omnibus Budget Reconciliation Act, and the State Children's Health Insurance Program (SCHIP), 46 million Americans, including more than 8 million children, were uninsured in 2007.[2] Hundreds of thousands have died from poor-quality care and preventable illness.[35] The current slow economy will unquestionably aggravate these distressing numbers and the financial and personal suffering they represent.

Market forces were applied to Medicare.[36,37] The Medicare part D drug bill contained provisions to expand the privatization of Medicare through the Medicare Advantage program. Yet the Medicare Advantage and the Medicare + Choice program before it have been less successful than the traditional Medicare program in controlling costs. Some seniors under these privatized competing Medicare programs actually received less choice of doctors and hospitals, decreased quality of care (especially for the sickest and poorest), and increased bureaucratic barriers to care. These programs seem designed to enrich the insurers, who receive 12% more than traditional Medicare would pay per enrollee. After recently dropping millions from their rolls because of low profitability, competing insurers were given financial incentives worth billions of dollars to take on seniors again.[36,37]

Market solutions such as health savings accounts and tax credits and subsidies for individual insurance policies continue to be debated.[38,39] However, health savings accounts have not gained much traction with consumers, and only some with employers.[40,41] Adding these accounts for all Medicare recipients would actually increase costs.[42]

According to the Congressional Budget Office, privatizing Medicare is unlikely to control program costs.[36] The agency's analysis of subsidies to help the working uninsured purchase private nongroup health insurance predicted that the voluntary purchase of insurance would rise from 16% with no subsidy to only 20% with half the premium subsidized.[43]

Tax subsidies, credits, and vouchers would encourage a shift from large public and employer-based group insurance to individual policies with higher insurance overhead.[44] When public subsidies were used to purchase private insurance for low-income SCHIP recipients, administrative

costs rose, and in general the coverage was worse.[45,46] Large public competitive purchasing pools for private insurance, such as the Federal Employee Health Benefit Program and California Public Employee Retirement System, have not controlled premium increases better than the traditional Medicare program.[47,48]

If market forces were an experimental drug in a trial to cure the dual problems of health care costs and lack of universal insurance coverage, the experiment would be terminated early as a dismal failure.

Mandates

Between 1988 and 1995, mandates for the purchase of private insurance by employers or individuals were passed by legislatures in Massachusetts (twice), Hawaii, Oregon, Minnesota, Tennessee, Vermont, and Washington. None of these plans succeeded in creating universal coverage or controlling costs, and the number of uninsured people was unaffected or grew larger over time.[49,50] These state-level reforms promised significant cost savings. However, none included real cost controls. As the costs soared, legislators backed off from enforcing the mandates or from financing new coverage for the poor.[49,50]

The latest Massachusetts mandate levies fines for failure to purchase insurance.[51–53] Massachusetts created a reformed insurance market called a connector to make affordable insurance available to all. More than half of the uninsured have been covered, but this was accomplished mainly with added public financing that subsidized the purchase of private insurance and expanded Medicaid. Most who did not qualify for subsidies have not purchased insurance despite the threat of fines.

Costs in Massachusetts have continued to climb, and copays and deductibles are likely to jump significantly.[51–53] The state has projected that program costs may run hundreds of millions of dollars over budget. Most would agree that this program is a critical test for health care reform. Although Massachusetts has quickly expanded coverage to the working poor, it remains to be seen whether affordability, cost control, quality improvement, and universal coverage can be accomplished or whether this latest attempt at mandates to purchase private insurance will fail as have others before it.[49,50,54]

Public Program Expansions

Public program expansions have demonstrated substantial durable success. The largest expansion of health insurance coverage to the uninsured occurred with the creation of the Medicare and Medicaid programs in 1965; more than 30 million people were enrolled by 1970.[55,56] According to the Center for Medicare and Medicaid Services, more than 90 million Americans are now covered by these programs.[55,56]

According to the Census Bureau, private employer-based insurance has been slowly eroding.[57] Sixty percent of employers offered insurance to their employees in 2007 versus 69% in 2000.[58] Nearly all of this decrease occurred among businesses employing fewer than 200 workers.[58]

After passage of the Balanced Budget Act of 1997, SCHIP covered millions of low-income children and their parents.[59] The states have used flexibility in the Medicaid program to expand coverage to other low-income individuals. Indeed, the 3 most expansive state programs to date, in Maine, Vermont, and Massachusetts, rely substantially on added federal Medicaid financing.[60–62] In general, it seems that public coverage works even for those most difficult to cover, such as the poor, persons with disabilities, and the elderly.

The political ideological divide that pits public program expansions against market-based solutions resurfaced in 2007.[63,64] President George W. Bush vetoed the SCHIP reauthorization bill despite bipartisan support. Bush maintained that expansions of public programs such as SCHIP "move the health care system in the wrong direction."[63]

LESSONS FROM HISTORY

American history abounds with examples of the struggle for power between the federal government and the states. As with other issues in American politics, health care reform efforts have oscillated between the state and federal level. In the case of social welfare legislation, the states have frequently been laboratories for social reforms that eventually make their way to the federal level.

Many states have enacted health care reforms that were initially heralded as paths to universal coverage but failed at implementation.[49,50,54] Others have passed and implemented incremental reforms or are planning more substantial reform.[65]

Proponents of a national health insurance program can learn much from the successes and failures of these state efforts. It is clear that the incremental health insurance market reforms attempted by many states have not succeeded in controlling costs or producing universal coverage.[54] The more substantial reform efforts in Vermont, Maine, and Massachusetts should be monitored to determine whether they can achieve and maintain universal coverage.

During a century of intermittent attempts to enact a national health program, federal health care reform legislation has mostly been incremental. This is not surprising. A significant majority of both houses (60 votes in the Senate) and enthusiastic presidential support are needed to pass sweeping social reform, and this kind of consensus is rare. The chance that broad support will materialize in at least 1 state is significantly higher.

History suggests that reforms are more likely to be adopted by the federal government if they first succeed at the state level. Examples include women's suffrage, child labor laws, unemployment insurance, social security, civil rights and antidiscrimination laws, environmental laws, and family and medical leave. All passed in states before federal action was taken. Successful state-based health care reform programs can be models for the nation.

Federal support for state-based universal coverage and cost control efforts should have bipartisan appeal. Presumably, conservatives would like to see more privatization and market reforms in their home states, and progressives would like to see expanded public programs and public accountability in theirs.

In addition to more resources, enabling legislation will be needed to grant flexibility in areas such as the Employee Retirement Income Security Act, tax policy (e.g., the extent that health insurance premiums are deductible), and some federal program regulations that inhibit states from attempting more comprehensive reform because of conflicts between state and federal authority.[66]

Special Versus Diffuse Interests

History has shown that legislative efforts usually involve cooperation between special interest groups represented by lobbyists, the state or federal agencies involved, and the legislature. The interests of the citizenry are diffuse: although the public is represented by the legislature, each individual legislator has only 1 vote but represents a multitude of interests. In the past, special interest groups such as physicians' organizations, the insurance industry, the hospital industry, health care suppliers, the pharmaceutical companies, and the organized business community fought to slow or prevent progress toward a national health care program.[67] Their financial strength allowed them to use the mass media to argue against reform, hire effective lobbyists, and provide substantial campaign contributions to friendly legislators.[68] In addition, there is a revolving door between jobs as legislators or government employees and lobbyists.[69] After their time of service, legislators and agency heads often end up as highly paid lobbyists who magnify the power of the special interests who can afford to hire them.

Currently, there are rifts among these interest groups. Providers are unhappy with the insurance industry in general and the excessive interference in the doctor–patient relationship by managed care organizations in particular.[70] This is a major change in the political landscape, because fifty-nine percent of physicians now support single-payer national health insurance, marking an increase of 10% in the past 5 years.[71]

A growing number of professional associations also support comprehensive universal national health insurance. Physicians for a National Health Program, the American Public Health Association, the National Women's Medical Association, the National Medical Association, the American College of Physicians, the American Medical Students Association, the American Nurses Association, and the Nurses National Organizing Committee have all announced support for a tax-financed single-payer national health insurance program such as that described in HR 676, the National Health Insurance Act.[72] This approach would create an improved and expanded Medicare for all.

Studies by the Government Accountability Office, the Congressional Budget Office, and multiple state governments consistently suggest that this approach could comprehensively cover every American at little or no additional cost, given the tremendous administrative savings that it would generate.[26,27,73–76]

Many other professional associations, including the American Academy of Family Practice, the American Academy of Pediatrics, and the American College of Physicians, have proposed incremental national plans that rely on government action to cover the uninsured and achieve universal coverage.[77] Even the American Medical Association, long an opponent of a national health insurance program, has produced an incremental plan for national universal coverage that relies on government action.[78]

Segments of organized labor and the business community are recognizing the burden placed on them by our inefficient health care system. Recent contract negotiations between the United Auto Workers and the auto industry reflect this change in attitude, with the auto workers accepting further responsibility for health care in retirement in the form of a voluntary employee beneficiary association.[79] New unexpected coalitions of business, labor, consumers, and providers are appearing in support of comprehensive health care reform.[80–83]

If national health insurance is eventually to carry the day, support must continue to grow among health care professionals. Inspired by personal experience of the deteriorating state of American health care and the actual effect of market forces on patients, they will have to show leadership and the courage to act in a coalition with other supporters of national health insurance and ultimately against the interests of some powerful groups, especially the insurance industry.

The business community might remain divided. Despite ideological support for market solutions, many business leaders understand that market forces have simply not achieved health care cost control; they may look pragmatically at solutions they see working in other countries.[84] This division among the special interest groups may provide an opportunity for significant reform.

Social Movements and Reform

History suggests that only an organized mass movement can apply the requisite pressure to finally win health care for all.[7,67] In contrast to incremental politics as usual, a mass movement or a strong national organization has often been essential to progress in social reforms. Examples of mass movements that played a crucial role include the movements for women's suffrage, civil rights, an end to the Vietnam war and the military draft, environmental protection, the organization of labor, and passage of laws mandating the 40-hour work week, workers' compensation, and restrictions on child labor. Powerful business and other special interest groups opposed these reforms, and state and national legislatures showed little willingness to act until organized mass movements in favor of change emerged.[85]

Citizens are beginning to organize around health care reform.[86–90]

Nonprofit organizations such as the Robert Wood Johnson Foundation and Community Catalyst are supporting consumer-level organizing.[89] Labor is actively supporting a national organizing effort for national health insurance.[90] HR 676, which would create an improved and expanded Medicare for all, has been endorsed by 443 labor organizations and 15 international unions. As of December 2008, 92 members of Congress were cosponsors. Religious organizations, strong supporters of national health insurance during the Clinton era, are beginning to involve themselves again: the Presbyterian General Assembly, Unitarian Universalists, United Church of Christ, and Methodist Church have all endorsed HR 676. An organized movement led by labor, religious organizations, and providers could be powerful enough to counterbalance the special interests likely to oppose fundamental reform efforts.

COMMON GROUND

What should be the balance of political power between insurers, suppliers, providers, and patients? Who should shape health care policy and determine health care spending? Not everyone is a conservative or a progressive, an insurance bureaucrat or a health care provider, but everyone will likely be a patient someday.

The Citizens' Health Care Working Group has shown us the common ground. The typical citizen-patient wants the outcomes from health care reform described by the Institute of Medicine[10]: universal continuous insurance coverage that is affordable and sustainable for individuals, families, and society, as well as health care that is effective, efficient, safe, timely, patient centered, and equitable.

The American College of Physicians has suggested that tax-financed single-payer universal health insurance (such as an improved and expanded Medicare for all, as proposed in HR 676) comes closest to meeting these goals for everyone at a reasonable price.[11,91] Medicare has proven its success through good and bad economies and through conservative and progressive political administrations.

By encouraging their public participation both as citizens (payers) and patients (users), tax-financed, single-payer universal health insurance could involve everyone in the process of controlling cost and maintaining quality. Communities could manage health care dollars for community benefit, not stockholder benefit.[92,93] Any ethical rationing or cost control rules should apply to all, including those making those rationing decisions and their families.[94]

Competition could still play a role in improving the quality of health care services. Providers could be given incentives to battle together efficiently against disease and disability, rather than competing for the best-paying patients and for duplicative technologies in every hospital. This competition against disease and disability would require and encourage cooperation and the dissemination of best practices and evidence-based medicine, and it is consistent with the Samaritan traditions of medicine rather than those of commercialism[39,95]:

Woolhandler and Himmelstein summarize how better reform may arise from cooperation than competition[96]:

> Health systems in every nation need innovation and improvement. But remedies imported from commerce consistently yield inferior care at inflated prices. Instead we prescribe adequate doses of public funds; budgeting on a community-wide scale to align investment with health priorities and stimulate cooperation among public health, primary, and hospital care; encouragement of local innovation; explicit empowerment of patients and their families; intensive audit for improvement, not reward or blame; a system based on trust and common purpose; and leadership not by corporations but by "imaginative, inspired, and . . . joyous people, invited to use their minds and their wills to cooperate in reinventing the system itself . . . because of the meaning it adds to their lives and the peace that it offers in their souls."[96(p129)]

Can America realize the dream of a health care system that meets the principles of the Citizens Health Care Working Group? The evidence suggests that market forces and competition between for-profit health insurers and providers will likely aggravate rather than resolve the problems of high cost, poor quality, and limited access. However, it is politically significant that traditional opponents of reform, including the American Medical Association and America's Health Insurance Plans, are beginning to suggest that some sort of a national health insurance system, albeit one that channels all the money through private health insurers, offers a viable alternative to the current failing sickness care nonsystem.[78,98]

If the lessons of history hold true, the enactment of universal health insurance at the national level will most likely follow enactment of a successful model at the state level. Federal support for state efforts could move the process forward and should be a priority. Untimely or inadequate efforts at the federal level could result in failure and another decade of waste, deterioration, and suffering.

History also suggests that a significant mass movement for sweeping health care reform will be needed, and it will require substantial leadership from the provider community, whose credibility will be needed to overcome the insurance and business interests likely to oppose fundamental reform. Physicians and other caregiving professionals must now turn their full attention to the creation of that mass movement. ■

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Public Health Workforce Enumeration

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Comprehensive data on the public health workforce are fundamental to workforce development throughout the public health system. Such information is also a critical data element in public health systems research, a growing area of study that can inform the practice of public health at all levels. However, methodologic and institutional issues challenge the development of comparable indicators for the federal, state, and local public health workforce.

A 2006–2007 Association of State and Territorial Health Officials workforce enumeration pilot project demonstrated the issues involved in collecting workforce data. This project illustrated key elements of an institutionalized national system of workforce enumeration, which would be needed for a robust, recurring count that provides a national picture of the public health workforce. (*Am J Public Health.* 2009;99:786–787. doi:10.2105/AJPH.2008.137539)

A NATIONAL WORKFORCE enumeration system is important for the assessment, advocacy, and accountability of the national public health workforce. Only by assessing the size and composition of the national workforce can agencies and organizations ensure that the workforce is large enough and skilled enough to deliver essential public health services to the US population. Descriptive data are critical to advocating increased resources for workforce development, such as the demonstration project and student loan repayment program of the Pandemic Flu and All Hazards Preparedness Act. The project and program, which seek to attract workers to the field of public health by offering student loan repayment, are currently unfunded. Advocacy for funding the project and program is hampered by a lack of national data on the current gaps that exist for qualified members of the workforce or vacant positions. Making the case for funding these types of activities requires compelling national data that show the urgent need for public health workers and the critical role they play in protecting the nation's health. Data are also needed to monitor the impact of these and other investments in the public health system toward achieving national public health goals. These data also would become an important basis for the growing body of public health systems research, yielding findings that can be used to strengthen all of public health practice.

A 2003 Association of State and Territorial Health Officials (ASTHO) survey showed a trend toward shortages in the state-level public health workforce; the 2007 update showed that state governmental public health systems still face a workforce crisis.[1,2] This trend has spurred interest in workforce data at the local and state level. In at least 5 states since 2000, state health agencies, universities, and public health institutes, in collaboration with local public health jurisdictions, have conducted enumerations of local public health workforces. Efforts to collect local public health workforce data are also occurring at the national level. The National Association of City and County Health Officials (NACCHO) collected the number of full-time equivalent workers in 13 occupational categories from NACCHO members.[3]

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